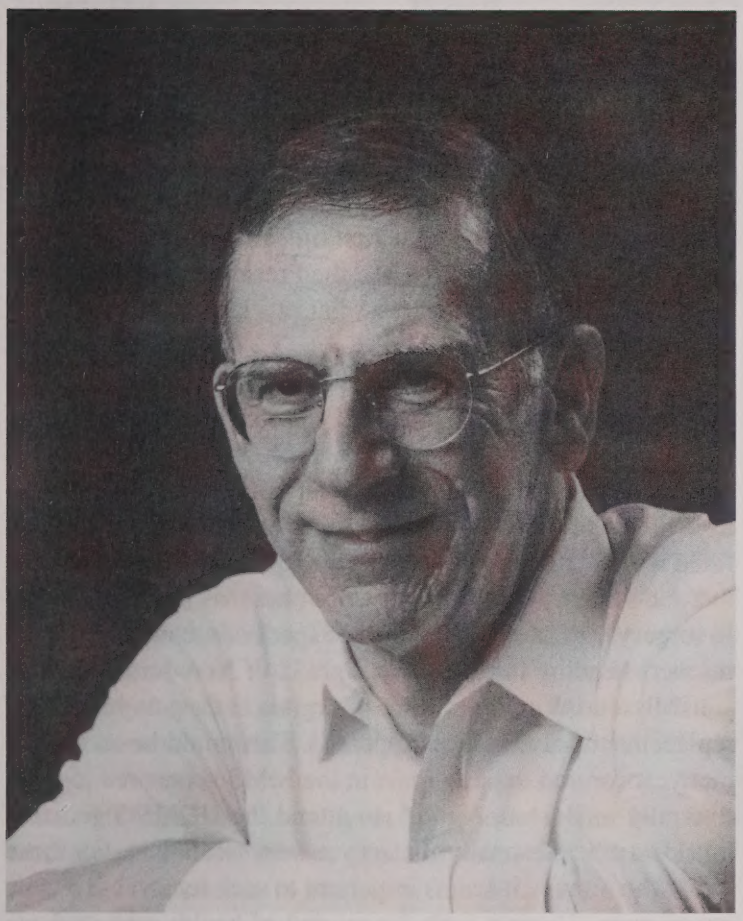
THE HAMPDEN HIPPOCRAT

The Hampden District Medical Society Newsletter

SPRING 2003 VOLUME 9

President's Address:



LONG BEFORE PROBLEMS WITH MALPRACTICE HAD ASSUMED THE MAGNITUDE OF A CRISIS

Long before problems with malpractice had assumed the magnitude of a crisis, and long before pressures from HMO's had forced physicians to step up the rate at which they saw patients, it wasn't the business, but rather the busy-ness, of medicine that alienated many of us from our patients.

Starting in college, where those bound for medical school typically had a reputation for nonstop work, nerdiness was transformed into a masochistic machismo while in medical school, particularly during the clinical years, and later into the stuff of war stories during post-graduate training. Slacking off or, more politely, enjoying some personal time, became tantamount to treason to the medical enterprise. Recalling "how {bad} it was when I was an intern" became a matter of pride and a measuring stick with which to size up the following generations.

By the time we reached our first practice situation, it was the rare individual who didn't measure personal worth by the total number of hours worked per week. Certainly there was a degree of imposed economic imperative, but the shame of unfilled time slots was probably an even greater impetus to double booking than any dollars lost. Of course, when everyone showed up, pushing each patient out the door in an efficient manner, an art form to some physicians, could become the source of resentment, bruised feelings, and more, among those patients.

If you have ever felt that you were given short shrift by the barber after he noticed how many customers were waiting, can you imagine how you would feel if your doctor hadn't had time to listen to and evaluate that last, and unfortunately most serious, embarrassing, and personal problem that you had been too scared to bring to his attention until the very end of your appointment?

Perhaps the first personal step each of us can take to reduce the friction that contributes to malpractice claims is simply taking more time for everyone, starting with ourselves.

Dennis S. Gordan, M.D.
President 2002-2003

Dr. Gordon presenting a HDMS jacket to Dr. Donald Palmisano, President elect of the AMA.

Executive Director's Comments

Hampden District Medical Society was established in 1840 and for the past one hundred and sixty four years the Society has maintained its mission statement:

……..to elevate the standards of medical practice, and to promote and protect the health of the public.

I have witnessed first hand how many of you are struggling with the decision to limit services, retire early, or move to another state where liability premiums are more stable. Yet, some of you continue to be dedicated and committed to work on behalf of your colleagues. Your professional lives are being overburdened, inundated, and encroached upon by others, leaving less and less time each day for professional, as well as personal endeavor. In this regard, I would like to thank those physicians who have volunteered their time, ideas, energy, and presence, on the Executive Committee, Task Forces, MMS House of Delegates, other district and state committees and for attending the "Rally for Reform" in Boston. Your dedication and commitment to your profession is to be commended.

Sincerely yours,
Suzanne T. Skibinski

LETTER POLICY

Letters to the editor should be approximately 250 words or less, preferably typed in Word. Please provide the full name and address of the writer along with a signature for verification. All letters are subject to editing.

Please **mail** to:

The Hampden Hippocrat
1111 Elm Street, Suite 22
West Springfield, MA 01089-1540
Or **e-mail** to: **Hampden@massmed.org**
Fax: 413-731-8990

The "Hampden Hippocrat Newsletter" is the news organ of the Hampden District Medical Society and would like to become the forum for sharing information and opinions amongst the members, for whom it is being created. Any article printed expresses the opinion of the author and should not be construed to imply endorsement by the HDMS.

Medicare and Medicaid Services

The Centers for Medicare and Medicaid services have posted a new and improved physician web page. The web page can be accessed at http://www.cms.hhs.gov/physicians/ there are many new features including a Physician Listserv and the Medicare Physician Fee Schedule Look-up.

Guest Editor's Column

This spring issue of the HDMS newsletter brings news of the AMA president-elected, Donald Palmisano's visit with us and Dr. Sankey's leadership conference visit to Washington, D.C. In this time of turmoil throughout the world, there is still a spring legislative season of proposed legislation and advocacy. I began my practice of surgery with the exit of malpractice insurance carriers from Massachusetts and the insolvency of the J.U.A (now Pro Mutual). The 'solution was the imposition of 300% surcharges to retroactively resolve the J.U.A.'s deficits. These were imposed on all who chose not to retire.

Nineteen years later, there are new giant step premium increases. This time we have national legislation with a proposed cap on non-economic damages in medical liability cases, among other needed reforms. For the first time, this legislation is supported by the party in power and the President. We also have a similar bill pending in the Massachusetts legislature and a lobbying season beginning.

While calls for reform in the past have not been heeded, this time it is possible that at least a portion of the community is finally making the connections. There is less access to care when physicians leave the community or partially or fully retired prematurely. This occurs in an environment of inadequate fixed reimbursements for care. Rising practice costs cannot be met and sudden jumps in malpractice rates may be the last straw. In surgery, we have bid farewell to experience, committed practitioners heading for the greener gra$$ of New Jersey, Michigan, Missouri, Virginia and West Virginia in the past year. Their replacements have not yet appeared. This could be an important year for you to participate in the MMS sponsored legislative rally in Boston, April 8, to attend the HDMS legislative breakfast or to personally contact your representatives. For those of us who remain, it seems important to seek renewal in a variety of ways. Contact with the myriad of health care students studying at our hospitals always seems ultimately re inspire the teacher. The HDMS "High School Doctor for a Day" program coming up soon gives a chance to inform and direct the aspirations of high school aged future medical practitioners.

The arts offer other members a re-invigoration and HDMS members can be found concertizing from the Springfield Symphony chorus to Northampton's First Night. Other members are exhibiting as visual artists in hospital and community galleries. A number of our colleagues, mostly unsung, have volunteered to bring their skills to undeserved areas abroad. HDMS members have contributed from Bosnia to Tanzania, from Nepal to Jamaica, some year after year.

"Tell me the truth about love, "said W.H. Auden. This is a belated valentine to our fellow colleagues who continue their sometimes ambivalent, bittersweet love affair with the practice of medicine. So scrape off the snow and smell the crocuses. It's spring.

Bridget Glackin, M.D.

2003 COMMUNITY CLINICIAN OF THE YEAR
Dr. Jean Talati

Dr. Jean Talati has been chosen to receive the Community Clinician of the Year Award. This award recognizes a member of the District who stands out as a leader, an advocate, a caregiver and who has made significant contributions to patients and the community. Congratulations to Dr. Talati.

A Letter of Nomination from a "Special Patient"

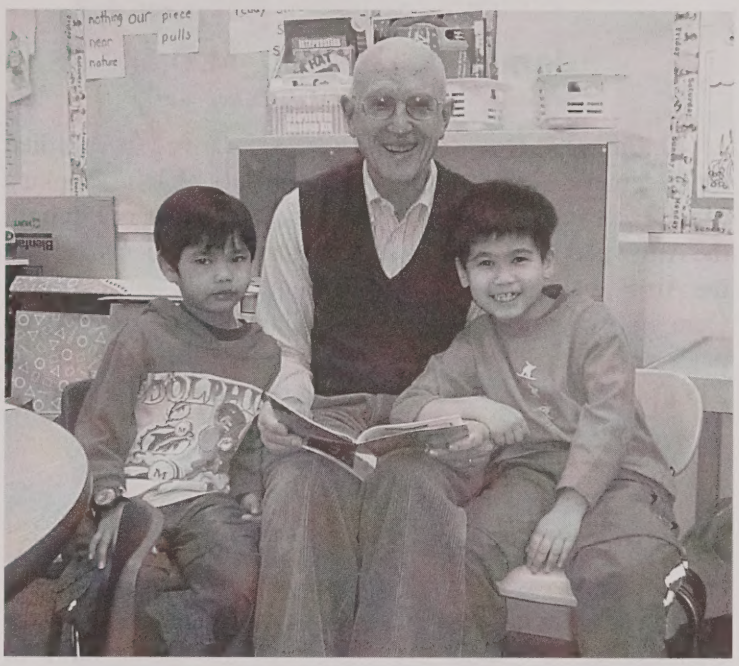
It is with great enthusiasm that I nominate Dr. Jean Talati, as recipient of the Hampden District Medical Society's, 2002-2003 Clinician of the Year Award. I have been a patient of Dr. Talati for approximately 17 years. She is extremely thorough and always has the time to answer all of my questions. I trust her judgment implicitly. She is an outstanding physician with a very warm heart. Dr. Talati works tirelessly, not only in her practice but in the community as well. She has devoted her time to the under-served, especially, working with the Holyoke community teenagers who don't have health insurance. In my opinion, Dr. Talati is not only an exceptional doctor but she is also an exceptional person who truly deserves this award. I hope that you choose to recognize her dedicated service, not only for being a wonderful physician but also as an exceptional person. Thank you for giving me the opportunity to nominate Dr. Talati for this Award.

Sincerely,
Judith Daniele, Human Resource Assistant
Baystate Health System

Dr. Talati, a practicing physician in OB/Gyn, has worked at Riverbend Medical Group since 1982. She is an Assistant Clinical Professor at Tufts Medical School and Baystate Medical Center. Dr. Talati's son Rakesh, is a resident in emergency medicine in Orlando Florida and her daughter, Raeka, is a junior at Wesleyan University. Dr. Talati and her husband Dr. Yeshvant, an E.R. physician at Holyoke Hospital, live in Longmeadow.

Dr. Talati, held the position of Secretary of the Society for many years and we congratulate her for her outstanding compassion, dedication and commitment to patients, community and the medical profession. Dr. Talati will accept her Award at the Annual District Meeting on May 06, 2003.

HAMPDEN DISTIRCT MEDICAL SOCIETY



Dr. H. Douglas Barnshaw

2003 SENIOR VOLUNTEER PHYSICIAN

The Hampden District Medical Society has added H. Douglas Barnshaw, M.D. to the distinguished roster of the HDMS Committee on Senior Volunteer Physicians. Dr. Barnshaw, a psychiatrist, worked in private practice in Springfield for 28 years before retiring in 2000. Dr. Barnshaw has been a steadfast member of the Public Health Committee for 18 years. Concerned over the lack of medical coverage for so many uninsured people he became a member of MassCare; an organization dedicated to advocating for Universal Medical Care via a single payer system. Since his retirement, he has diligently offered his assistance to the residents of the City of Springfield as an active volunteer. He is on the Board of Child and Family Services of Pioneer Valley, Co Chair of the Education Committee of Pioneer Valley, an outreach project that is working with families of students attending Washington Street School. He is tutoring six Vietnamese students and a mentor to another and, volunteers in the Re-Seed program at Duggan Jr. High School. He volunteers as a Docent at the Museum of Science in Springfield and is also very active in the Unitarian Universalistic Society serving as Co-Chair of its Stewardship Committee. Dr. Barnshaw still finds time to work part time doing psychiatric evaluations and follow-up monitoring of medications at the Community Care Day Treatment Program in Springfield. He and his wife Libby reside in Springfield.

The Hampden District Medical Society extends its sincerest thanks to Dr. Barnshaw for his service to his community as a dedicated physician and volunteer for 39 years.

Dr. Barnshaw will be presented his Award at the Annual Meeting.

Obituaries

James A. Doering, M.D.
1921-2002

Dr. James A. Doering a pediatrician for over 50 years died on December 29, 2002. He was a graduate of John Hopkins Medical School. While a medical student, he served in both the Army and Navy Scholarship programs, and then served in the Air Force as a physician and Captain. His wife, Roberta Gere Doering, survives him. Memorial contributions may be made to the YMCA of Greater Springfield Camp Norwich Fund, 275 Chestnut Street Springfield, MA 01104

Joseph M. DiNardo
1926-2003

Dr. James M. DiNardo passed away on February 25, 2003 after a long illness. He was a cardiologist in private practice in Westfield for 28 years. He was a graduate of the University of Geneva Medical School in Geneva. He held the positions of Director of Cardiology and the Director of the Coronary Care Unit at Noble Hospital in Westfield. His professional honors include a Fellow of the American College of Anginology, a Fellow of Council of Geriatric Cardiology and recipient of the Physician's Recognition Award of the American Medical Association. Dr. DiNardo leaves his wife Lydia, a son, two daughters and six grandchildren. Donations may be sent to the American Heart Association, Heart Gift Processing Unit, Box 3049, Syracuse New York, 13220.

A Thank You Letter to the District

Dear Suzanne, Dennis, Executive Committee and members of the HDMS. The entire Stoler family is most grateful for the memorial gift to Primarily Primates, Inc. in memory of Mrs. Stoler. She would have been pleased as well, for she was a longtime supporter of their work. I was touched by this gesture on your part.

Sincere regards,
Dr. Bruce Stoler
President, 1976-1977

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SENIOR STATUS

Dhipati Chandra
Norman Halpern
Alvin Keroack
Mark Pohlman
Philip Stoddard

EMERITUS

Augusto G. Asinas, M.D.
John E. McHugh

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ATTENTION!!! DOCTORS!!! ATTENTION!!!

Don't Forget to Contact the HDMS Office if you change your medical office/practice address to be sure your file is updated.

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WELCOME NEW MEMBERS

ANESTHESIOLOGY
Frank W. Dupont
Jane Gotta
Nada Y. Usta-Makkaoui

NEPHROLOGY
Krishnan Babu

ORAL & MAXIFFOFACIAL SUEGERY
Brett Denhart

PEDIATRIC ENDOCRINOLOGY
Holly Allen

PEDIATRICS
Michelle Adams
Tracey J. Browning
Thomas Guggina
Paul W. Taylor

OPHTHALMOLOGY
Pamela Henderson

INFECTIOUS DISEASE
David Longworth

INTERNAL MEDICINE
Sandra Bellantoni (Geriatrics)
Alejandro J. Espara-Perez
Philip Gaziano (Geriatrics/Hospitalist)
Tariq Malik (cardiology)
John Marenco

Meera Ravikumar
Lois C. Albury

OTOLARYNGOLOGY
Theodore Mason

PSYCHIATRY
Katherine Eisenmenger

UROLOGY
William E. Swanson

WELCOME BMC RESIDENTS

Laura Kraus, Pediatrics
Yin Ping Liew, Internal Medicine
Wanda Rivera, Internal Medicine
Michael F. Canarie, Internal Medicine
Kelly L. Hickey, Pathologist
Agarwal Diwaker, Radiology
Leslie Arpin, Pediatrics

HDMS Congratulates Our 50 Year Members 1953 – 2003

Four physicians who dedicated their careers to helping others will be honored at the Annual Meeting, May 6, 2003

Edward F. Caruso, M.D.
Howard R. Grawford, M.D.
Howard G. Turner, M.D.
Edmond M. Walence, M.D.

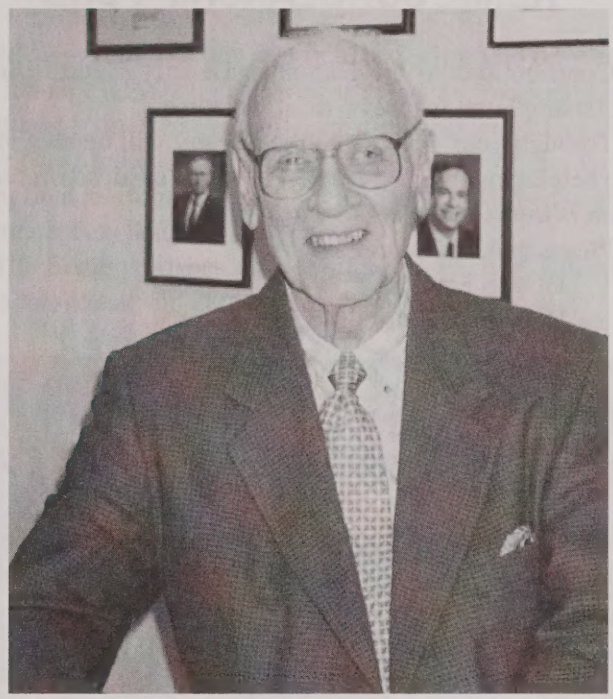
How many more years will we have the honor of being able to present this Award of Achievement? Fifty years as a member of Hampden District Medical Society translates into many more years in medicine itself. With the changing healthcare environment and mounting pressures on the profession, physicians are diversifying their interests and are learning that life does exist outside of medicine. This year we have four fifty-year Members who dedicated their careers to helping others. They are the physicians who taught the next generation of physicians who passed their knowledge on to the next, and …so on…They are the link in the continuum of time reaching back to Hippocrates and forward to discoveries yet to be made by physicians yet to be born. Apropos to the concept on time, on behalf of Hampden District Medical Society, our fifty-year members will be presented a fifty-year certificate and a mantel clock, personalized with a brass nameplate at the Annual Meeting on May 06, 2003. **Please join us in acknowledging and celebrating their achievement**.

THE SALVATION ARMY ADULT DAY HEALTH

- Any disabled adult or frail elder 18 years of age or older
- Basic rate of $41.42 per day
- Transportation is $5.09 each way via Salvation Army van
- Medicare pays for the program and transportation
- A daily nutritional lunch is provided
- Morning and afternoon snacks provided
- Professional staff including 2 on site nurses for each individual
- Activity director conducts a structured program
- Minimum participation, 2 days
- Maximum participation, 5 days

Contact, Walter Richter, Sales & Marketing Director at 413-562-6268 or 413-737-3990

Taking On the Orchestra



At the Springfield Symphony Orchestra's recent Pops concert, Kevin Rhodes, the orchestra, chorus and audience were caught in mid-note by a surprise soloist. As the orchestra was performing, a patron began playing along with the orchestra on a harmonica. Following the end of the work, a smiling Rhodes grabbed his microphone and jumped down from the stage, found the patron – **Dr. Samuel F. Potsubay** of South Hadley – and asked him to repeat the song. Potsubay obliged to a great round of applause. Maybe the SSO has a potential harmonica soloist in its future. Dr. Potsubay is one of Hampden's senior members.

Calling for Nominations For: Hampden District Medical Society *Oliver Wendell Holmes, M.D. Stethoscope Award*

Candidates for this award are selected for their wit and philosophy of the practicing physician. The Award will be presented on September 23, 2003 at the Fall District Meeting.

Please submit your nominations with a supporting letter by: August 1, 2003 to:

Suzanne Skibinski,
Executive Director HDMS
Hampden District Medical Society
1111 Elm Street, Suite 22
West Springfield, MA 01089 or email to
Hampden@massmed.org

HDMS, SCHOLARSHIP FUND

Contributions to the Hampden District Medical Society Scholarship Fund would be most welcome…

Through your generosity, the Society will be able to continue helping medical students. **Please be assured *that no donation is too small to make a difference.***

Please make donations out to:

HDMS Scholarship Fund
Hampden District Medical Society
1111 Elm Street Suite 22
West Springfield, MA 01089-1540

* * PCC REFERRAL REQUIREMENTS * *

Acute hospital providers are reminded that, effective October 01, 2002, they no longer need a referral from a MassHealth primary care clinician (PCC) for PCC plan members seen in a emergency departments (ED) for non-emergent care. Also effective October 01, 2002, a PCC referral is not required for elective admissions. However, hospitals must still obtain pre admission screening (PAS) approval for elective admissions. When a MassHealth member is enrolled with a PCC, you must notify the PCC within 48 hours of these types of treatment. This notification can be either written or verbal. The patient's medical record should indicate that their PCC was notified within the 48-hour time frame. PCC information is obtained when verifying member eligibility through the MassHealth recipient eligibility verification system (REVS.)
If you have additional questions, contact MassHealth Provider Services at 617-628-4141 or 800-325-5231.

Donald J. Palmisano, M.D. 159th President of the AMA

Donald J. Palmisano, M.D., President-Elect of the AMA, discussed the medical liability crisis at four different venues with four separate groups during his January 21-22, 2003, visit to Springfield. With talks tailored to his audiences, he spoke and responded to questions at the Hampden District's Winter meeting at the Best Western Sovereign Hotel in West Springfield on Tuesday evening, at Baystate Medical Center's Medical Ground Rounds on Wednesday morning, to interested members of the public at Springfield City Hall later that morning, and at the Kiwanis' monthly luncheon at noon. Between engagements and on the way to the airport, he was constantly on his cell phone, speaking to his office, AMA headquarters, or a line of interviewers referred to him by the AMA for the latest on the AMA's positions and activities.

Regardless of his audience, Dr. Palmisano's message remained the same: Despite a true crisis in medical liability insurance, and perhaps because of it, conditions have never been better for effecting medical tort reform that will mean fairer compensation for anyone harmed by a medical misadventure, and continued access to care for all Americans. On a national level, this would be a replay of the situations, starting in California and Louisiana in 1975, when, because of systems that were not working, MICRA (in California), the Louisiana Medical Malpractice Law, and similar laws in New Mexico, Indiana, Wisconsin, and Colorado, were passed. Through several mechanisms, but primarily by a firm cap on non-economic damages, these laws have resulted in appropriate compensation to injured patients, while decreasing the harm that frivolous suits do to physicians and medical practices, while limiting premium increases to about a quarter of what they have become in 12 "crisis" states, such as Florida. Whereas rates for obstetricians in California and Florida were approximately equal in 1975, California's is now $52 to $55,000 per year, while Florida's is $202,000. The remaining 32 states have problems.

The reason Dr. Palmisano calls the liability situation a crisis is because access to care disappears, regardless of a patient's insurance plan or ability to pay, when high malpractice premiums drive physicians into retirement or out of a state. The operative word is "when," not "if," because physicians are dropping out now, particularly in high risk specialties such as OB, neurosurgery, and emergency medicine. Patients are having to travel long distances to get care; the time involved in such travel, particularly for emergency care, frequently increases the risk to their health. The result, according to multiple examples given by Dr. Palmisano, is a situation resembling that in an undeveloped country. The fact that liability relief works was demonstrated by the return of emergency physicians to ER's in Nevada once that state capped the <u>total</u> liability for a mishap in the ER at $50,000 (a cap that the AMA feels is too stringent, especially since it ignores economic loss.)

It is the AMA's position that skyrocketing premiums are caused by the lack of caps on non-economic damages. Some groups have tried to blame the premium increases on other factors; three favorites are investment losses by insurers over the last few years, big profits by insurers, and the bad 5% of physicians that they claim are responsible for 50% of the awards. Dr. Palmisano worked his way through all these claimed causes, presenting evidence that none was true. He noted that the AMA had investigated and found:

1. Investment losses are not occurring. Malpractice insurers have reported steady investment income of 5 to 5.5 percent for the last several years in spite of the stock market's performance. The simple reason is that regulations governing their operations mandate conservative investments in bonds and government securities.
2. Insurers are not reaping big profits. Data from the National Association of Insurance Commissioners indicate that malpractice insurers are paying out, in awards, one and a half times what they are taking in as premiums, a situation that, clearly, can not continue.
3. While the AMA is for safety and discovering "bad" doctors, "bad" doctors are simply not the problem. Some of this misinformation regarding "bad" doctors comes from the National Practitioner Data Bank, which

is rife with error. Further, a Harvard study has shown that there is no correlation between money paid and negligence, although there is a correlation between awards and the disability of the plaintiff. Such disability is often the result; despite the best of care (a fact, which received further support in the recent study of the causes of cerebral palsy by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.) About 70% of obstetricians have been sued, and the average OB can expect between 2 and 3 suits in a lifetime.

There is also the claim that caps simply do not work, but this idea results from caps that are not, in fact, caps. In some states, a $250,000 cap is a cap per practitioner involved, per institution, per isolated event that led to the bad outcome, and per claimant (i.e., every family member of the injured patient.) Once those are multiplied out, the cap is in the millions, and the data show that caps over $250,000 do not remove the incentives for frivolous suits. A strict non-economic cap of $250,000 and elimination of joint and several liability, such as in California under MICRA, has, in fact, worked.

What is needed is something like the Aviation Safety Reporting System, which seeks reporting of all errors in order to achieve non-punitive systemic corrections, so such errors do not recur. (This is, in fact, similar to an initiative introduced to the Massachusetts Medical Society House of Delegates by Dr. Manuel.)

Dr. Palmisano feels that the changes supported by the AMA are more likely to succeed now than ever, because so many in government, including President Bush and Secretary Thompson, and the public are for them. He, thus, feels free to tell the medical students, with whom he has contact on a nearly weekly basis, that their futures are bright, since the system will either have melted down and been rebuilt or the AMA's efforts will have been successful.

Dennis S. Gordan, M.D.

Winter District Meeting
Dr. Dennis Gordan and Dr. Gregory Gallivan

Town Hall Meeting

A Town Hall Meeting was held in Springfield on Wednesday, January 22,2003. The meeting was an invigorating and informative interchange between the President-Elect of the American Medical Association and citizens of the Greater Springfield metropolitan area. A large turnout helped to ensure the greatest exchange of opinions and ideas.

The Society wishes to thank Mayor Michael Albano for his endorsement and enthusiastic support of the event.

Town Hall Meeting in progress.

Town Hall Meeting
Dr. Dennis Gordan and Dr. Mark Mullan

ATTENTION PHYSICIANS!!!

If you are volunteering in a free or reduced rate clinic treating the under-served population, please fill out the form below.

CLIP and RETURN TO:
Hampden District Medical Society
1111 Elm Street Suite 22
West Springfield, MA 01089-1540
Fax 731-8990 or email hampden@massmed.org

Name:_____

Specialty:_____

Phone:_____Fax:_____

Clinic Address:_____

Hours:_____

FREE AND REDUCED RATE CLINICS

Brightwood Health Riverview Clinic
380 Plainfield Street
Springfield, MA 01107
794-4458 (By: Appointment)

Springfield Southwest Community Health Center
1040 Main Street
Springfield, MA 01107
739-1100 (Walk-in)

Adult Internal Medicine Clinic
140 High Street
Springfield, MA 01199
794-2511

Pediatric Ambulatory Services
140 High Street
Springfield, MA 01199
794-2515

Mason Square Neighborhood Health Center
11 Wilbraham Road
Springfield, MA 01199 (Walk-in)
794-3710

Holyoke Health Center
30 Center Street (536-8761) 317 Maple Street (536-8711)
Holyoke, MA 01040 (Walk-ins: Emergency Care only)

Chicopee Health Center
203 Exchange Street
Chicopee, MA call Holyoke Health Center (536-8761)

Southwest Health Center
532 Sumner Avenue
Springfield, MA 739-1100

Tapestry Health Systems
39 Mulberry Street
Springfield, MA 733-6639

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MMS Committee on Senior Volunteer Physicians

The goal of the Committee on Senior Volunteer Physicians (CSVP/"Committee") is to utilize the experience and skills of senior and/or retired physicians to fulfill the medical and health education needs of communities throughout the state. Since its inception in 1994, the Committee has established the Health Center Program, Mentorship Program, and Education Outreach Program, enabling retired physicians to volunteer in their particular area of interest.

The Committee's Health Center Program makes it possible for licensed and insured volunteer physicians to provide health care to uninsured and under-served populations, in large part through its provision of professional liability insurance. The number of retired volunteer physicians participating in the program has steadily increased over the past few years and currently has fourteen physicians volunteering in free care clinics primarily in Boston, Worcester, and Cape Cod. In addition, the Committee regularly invites presentations from free care clinics and health centers to evaluate and identify their volunteer needs.

The Program has proved to be a highly rewarding and mutually benefiting experience for senior volunteer physicians, the programs in which they participate, and the patients they serve. Licensed physicians interested in participating in the Program are required to obtain Committee approval for the specific volunteer activity in which they are interested in participating. Upon Committee approval, the physician is also required to sign a Volunteer Agreement. In addition, the physician must supply proof that they are a licensed physician in Massachusetts, as well as obtain a letter of explanation from the physician overseeing their volunteer activity.

In light of its success, the Committee plans to expand the Program and remains dedicated to fulfilling their goal of providing quality health care to uninsured and under-served **population, exemplifying the Society's maxim, Physicians Caring For Massachusetts. Contact Erin Riley, 800-322-2303**

President's Forum & AMA National Advocacy Conference March 3-5, 2003

Dr. Heather Z. Sankey, Senator Ted Kennedy and other forum participants.

As President-Elect of Hampden District, I signed up to go down to Washington for what used to be called the "AMA Leadership Conference." Well, they not only changed the name this year, but they changed the entire format, which I'll tell you about a little later.

The first thing I learned was how much airline security has changed, even in the past year. Okay, I expected to have my checked bags go through the x-ray machine, and I carefully packed my dangerous crochet hook, and little sewing scissors away in my luggage so they wouldn't be taken away. But my efforts to avoid setting off the security detector by wearing a bra without an underwire were in vain. My necklace, the snaps on my sweater, the little pin I wore all set it off, and it turned out that my boots have metal plates in the bottom. Who knew? By the time I saw the dog sniffing everyone's luggage at the terminal, I was just glad that I packed celery for a snack instead of beef jerky. At least the dog kept all of the little kids from crying…

Well, onto the meeting itself. It was packed. The first day, which was the President's Forum part of things, was standing room only until they caught on as to how many people were actually there. It was a little hard to eat breakfast standing up, but at least it was bagels, not eggs. We heard from all the top honchos at the AMA, mostly about professional liability issues. There were two breakout sessions: Ethics in Board Governance, and Public Perception of the Medical Profession. We also heard about a huge collaborative effort to declare March 10-16th to be "Cover the Uninsured Week." The Robert Wood Johnson Foundation is leading this. They are not recommending a specific solution, but trying to raise awareness of the problem (covertheuninsured.com).

These were followed by an excellent discussion of tort reform. We heard from a panel including the presidents of the Texas, Florida and Pennsylvania medical societies on some of the things they have accomplished. The president of NJ medical society wasn't on the panel but spoke from the floor. He described their efforts to effect change as a "leave of absence" from medicine. Interestingly, they had demonstrated in front of a Red Cross center, and then went in to give blood. (Were they expecting the bloodbath from the media that they got??) Anyway, the lesson I learned is that the media gets more mileage out of talking about strikes and taking pictures of angry podiatrists waving big signs (USA Today).

Here are some of the interesting points raised:

- There is a direct inverse correlation between # of state tort reforms passed and premiums.
- National Data bank shows that million dollar jury awards went from 0-3 a year to 15 per year in 2001 and 2002 in Pennsylvania.
- California's premiums increased 169% from 1977 to 2000, while the rest of the country increased by 455% over the same period of time. California has the MICRA legislation with a $250,000 cap on non-economic damages.
- Pennsylvania looked at the allegation that payouts are related to "bad doctors." They disputed this by showing that there are very few physicians with more than one payout. In specialities such as Obstetrics and Neurosurgery where most physicians get sued at least once in their career, this is easy to dispute as well.

On Monday night the National Advocacy Conference began with more discussion of liability, specifically the HEALTH Act, H.R. 5. Tuesday morning began at the crack of dawn with another metal detector and bag search so that we could hear President Bush speak. The morning actually began with Senator Frist, and a few others before Pres. Bush. The media was out in force, so he started with comments on Iraq - which were most of what was carried on the news throughout the day, but he did speak in support of liability reform, and presented a general proposal for Medicare. Tuesday was really packed. By Tuesday night when we went to a reception held by Speaker Hastert, we had heard from 5 congressman, 2 senators, Justice Scalia, the head of AARP, and the director of the Federal Employee Health Benefits Program (on which the president's medicare reform is based). Whew!! I got a lot of crocheting done.

On Wednesday we heard from the Surgeon General, the Commissioner of the FDA (who is looking to recruit doctors if anyone wants a job change), and Thomas Scully, head of Medicare and Medicaid. By this point, the Massachusetts delegation was off to meet with Senator Ted Kennedy and his dogs.

We met as a (large) group with Senator Kennedy. He has really cute dogs. Knowing he would never support outright tort reform, I was happy that he took the time to listen to us. He agreed to send his Health Aide up to Massachusetts to meet with a group from MMS to look into the facts around the current crisis, and promised to meet with this group personally once some preliminary work was done.

Senator Kerry wasn't available, but we met with his Health Aide, Kelly, who is very knowledgeable. I had met with her last year, and in contrast, this year she seemed to be looking for something that Kerry could support. He won't vote for the house bill, but has met with Senator Feinstein, to at least talk about a possible alternative.

Finally, I met with Congressman Olver and his Health Aide,

Annie. I also had met with him last year, and all he could say then was, "You're giving me a headache!" This year, he said, "This feels like a root canal!" I think that was an improvement, but I'm not sure. Anyway, we spoke for about an hour, and he grilled me. At the end he said that I had an answer for everything he could think of to ask. I asked him to consider all the issues I had raised and keep his eyes open for something that he could feel comfortable supporting. He is fully aware that we are in crisis in Western Massachusetts and that his area is really a rural area: not like Boston with it's many physicians and hospitals. He seemed to be looking for a way to justify to his party if he votes for tort reform. As Kerry's aide had pointed out, however, it came out of sub-committee on Tuesday with a bunch of changes (adding in protection for HMO's for instance), and is expected to get to the floor for a vote next week, after getting through two more committee opportunities to modify. So who knows what it will look like by that point.

Overall, I would say that the meeting had some very high level speakers, it was well run (although we could have used more snacks) and MMS was terrific. All of the legislative staff were there helping to get us to where we needed to go on Wednesday, and guiding us on how to work well with our politicians. To top it all off, after two rather cold days, Wednesday felt like spring was coming - and some day that will happen up here, too!

In comparison to the ACOG Legislative Workshop that I attended last April, this had less education about the process, but was certainly a worthwhile experience. Although the President's Forum was for officers, everyone is welcome to the NAC, and I'd recommend it if you feel a need to talk with your representatives in D.C.

Exploiting Your Resources: Interventional Radiology

Julia Gates, M.D.
Interventional Radiologist

Overview:

Cardiovascular and Interventional Radiology (CVIR) is a little understood outgrowth of Diagnostic Radiology; it is frequently underutilized. Interventional radiologists (IRs), unlike many of their diagnostic colleagues, work as clinical consultants and actively seek a role in patient assessment, management, therapies, and cures. The services interventional radiologists provide are myriad **(Table1)** This article is the first of a series dedicated to enlightening professionals as to what CVIR can offer and how it should be used.

The services CVIR offer overlap to some degree with those provided by other disciplines. Frequently, referring physicians are simply unaware that similar care can be provided by IRs. There are reasons why the CVIR division should be used preferentially. Some of these reasons include accessibility (operating rooms may be overbooked); decreased costs (CVIR suites are less expensive to run than are operating rooms; this makes hospital administrators happy); image guidance shortens procedure time, improves accuracy and reduces complications; and expertise (IRs may do certain procedures more often than do colleagues in other disciplines which in turn may mean that IRs can do these procedures better, faster and with fewer complications). This may cause turf issues which is unfortunate. A harmonious, collegial environment would be ideal in consideration of working towards a common goal: the welfare of the patient and the improved provision of health care to the community.

PICCs:

Consider the placement of PICCs (Peripherally Inserted Central Venous Catheters), for example. These slender, extra-long intravenous lines are seemingly, little innocuous devices which nurses or physician assistants routinely place at the patient's bedside or at home. So why call on an IR? Depending on the operator (vis-à-vis a nurse counterpart) the procedure time may be shorter (increased patient satisfaction); a sterile field is easier to maintain in an CVIR suite; the placement is performed with image guidance (i.e. ultrasound and fluoroscopy) resulting in fewer needle sticks to make a successful venopuncture and the tip of the catheter is perfectly positioned in the lower superior vena cava. Needless to say, a well positioned PICC is an obvious advantage over peripheral intravenous catheters which should be changed every 72 hours and result in great angst for patients requiring long term intravenous access.

In some institutions, bedside insertions are part of a two stage approach at PICC placement: PICC nurse followed by IR. Having failed the former, the patient is then sent to CVIR for the definitive procedure. This approach may or may not be cost or time effective, depending on the success rate for bedside placement. Some patients may be "difficult sticks" in the absence or even presence of image guidance. People who have few veins (e.g. intravenous drug abusers, after chemotherapy, following surgical procedures, dialysis patients) or central venous stenoses or obstructions; those patients with severe edema or marked obesity; patients with spasticity or contractures; anxious or confused patients requiring sedation; and children may best be served by an IR.

Why? The placement of PICCs in the CVIR suite consists of a direct venopuncture, usually on the first attempt, under ultrasound guidance after the administration of a local anesthetic and the placement of the catheter in an optimized location; this is performed under sterile conditions. The total procedure time should be less than 15 minutes (typically 5-7 minutes); an arterial puncture is not inadvertently done; multiple

needle sticks are avoided and the procedure is almost pain-free. Optimized PICC placement means that the catheter need not be repositioned after a chest radiograph (this is obviated by using fluoroscopic guidance) nor must the referring physician be concerned about the perils of an improperly located catheter tip (recalling that certain infusates can cause central venous stenoses from catheters placed too peripherally). The catheter can remain in place for six weeks or longer, with proper maintenance.

Conclusion:

Your local IR is there to serve the referring physician, the patient and other allied health professionals. Some, but not all, of the procedures

done by IR are listed below. Consider consulting with her/him the next time you have a question about a procedure or condition, which might streamline your patient's care. Safer, faster, painless approaches to a problem can frequently be found in the CVIR division; many of these approaches can be performed on an outpatient basis.

Table 1. Interventional Radiology Services - Diagnostic:
Arteriography:
Aortography.
Adrenal.
Bronchial.
Carotid/Vertebral .
Donor (liver, renal).
Femoral.
Mesenteric.
Pelvic.
Peripheral.
Pulmonary.
Renal.
Spinal.
Biliary:
Biliary Whittaker test (for biliary obstruction).
Percutaneous cholangiography (for biliary obstruction).
Post-procedural cholangiography.
Gastrointestinal: Post-procedural contrast studies (for leakage etc.).
Renal:
Renal Whittaker (for renal obstruction).
Percutaneous pyelography (for renal obstruction).
Venography:
Lower extremity (difficult diagnoses, before lytic therapy.
Mesenteric/Portal.
Neck.
Pelvic.
Pulmonary.
Renal.
Upper extremity.
Venous sampling:
Adrenal (for adrenal tumors).
Hepatic.
Parathyroid (for hyperparathyroidism).
Renal (for hypertension).

Therapeutic Interventional:
Biliary: Cholecystostomy (for acalculous cholecystitis).
Internal/external stents (for biliary obstruction).
Internal stent (for malignant biliary obstruction).
Percutaneous drainage (for biliary obstruction).
Embolization: Arteriovenous malformations.
Bronchial (for severe hemoptysis).
Chemoembolization (for unresectable tumors).
Fibroids.
GI Hemorrhage.
Hepatic (for trauma, tumor, other bleeding).
Pelvic (for trauma, tumor, post-partum, other bleeding).
Peripheral.
Pulmonary (for arteriovenous malformations).
Renal (for trauma, post-biopsy, tumor, other bleeding).
Splenic (for trauma, hypersplenism).
Trauma.
Tumor/Metastases.
Gastrointestinal:
Percutaneous gastrostomy and gastrojejunostomy.
Jejunostomy.
Cecostomy.
Stenting (for malignant obstruction).
Renal:
Nephrostomy.
Ureteric stenting.
Vascular:
Aortic fenestration (for aortic dissection).
Angioplasty (for arterial, graft and venous obstruction).
Stenting (for arterial, graft and venous obstruction).
Aortic stent grafting (for aneurysms).
Caval filters (for recurrent thromboembolic disease).
Thrombolysis for acute thrombosis.
TIPSS (for recurrent variceal hemorrhage, refractory ascites due to portal hypertension, hepatic hydrothorax).
Venous access (PICCs, tunneled catheters, ports, difficult access
problems).
Vasodilator/vasoconstrictor/chemotherapy infusion.
Foreign body retrieval.
Miscellaneous:
Abscess and other difficult drainages (under CT guidance).
Difficult biopsies (under CT guidance).
Vertebroplasty.

WorldScopes
Donate a Stethoscope for World Health

The American Medical Association's new Caring for Humanity initiative extends medicine's mission to care for the sick and suffering beyond U.S. borders. The first Caring for Humanity project is **WorldScopes**, a campaign to collect 100,000 stethoscopes from U.S. physicians and distribute them to communities around the world. To donate a new or used stethoscope please call 736-0661 and we will gladly pick it up.

Health Disparity in the United States: A major Problem in Search of a Solution.

Claudia Martorell, MD
Fellow, Infectious Diseases BMC
HDMS Public Health Committee

Health care disparity is still a major problem in the 21st century. Disparity is a public health issue that has been studied for at least 20 years, and it has recently acquired increased attention for its impact in healthcare provided in which equity has not been successfully achieved. There are approximately eighty studies on health disparity, the majority related to the cardiac field where a difference between whites and non-whites has been documented in diagnostic and treatment modalities. This problem is not unique to the cardiac field, and some of these studies have evidenced that disparities remain after controlling for clinical and socioeconomic factors. Is the race of a patient promoting a different treatment modality?

Health disparity is difficult to solve although not impossible; it probably needs a complete restructuring of the health care system. Extensive research is needed to investigate underlying causes and effective interventions that will help reduce ethnic disparities in medical care. The recent publication of "Crossing the Quality Chasm" by the Institute of Medicine, has led to organizations like the AMA, AHA, the National Hispanic Medical Association and the Kaiser Family Foundation, among others, to pursue an aggressive educational campaign to increase awareness about health disparity existence. Health care workers need to know that clinical guidelines are not being followed with every patient served, and physician biases in the diagnostic, treatment and referral process are expected to decrease by increasing awareness of the problem.

An important factor to decrease health care disparity is the development of the cultural-competent healthcare environment. A cultural competent multidisciplinary health care team will probably increase patient compliance with prevention and treatment modalities and will help satisfy the needs of the minority population and reduce health disparity. Communication and collaboration between primary care doctors and specialists should exist. Translation services should be mandatory when needed. Case managers should be available in settings where it is imperative that patients keep follow up appointments with all the physician and non-physician providers. Ancillary personnel are needed to assist in filling forms or applications for services that will facilitate and benefit the patient.

Health disparity and cultural-competence are issues that must be included in all healthrelated curriculums, especially in medical schools and residency programs. Limited minority recruitment and participation in medical schools, limited presence of minority staff in academic settings and research, and limited minority participation in health policy issues are some examples of the problems that affect the minority sectors within the health care system. It is important to increase minority physicians and healthcare providers in leadership positions those impact decision making capacity and policy issues that affect minority care needs in the United States.

Equity for all in America is a goal that contemplates a challenging experience that require commitment and an active role in shaping and influencing the ongoing changes in the health care system services. Equity means elimination of health disparities.

Screening for Group B Streptococci in Pregnant Women

Throughout a pregnancy, a woman must undergo important prenatal testing crucial to the welfare of her baby and herself. One of these tests is the screening for Group B beta-hemolytic Streptococcus. Group B beta-hemolytic streptococci (GBS) or *Streptococcus agalactiae* are Gram positive bacteria found among the normal flora of the intestinal tract and the female genital tract. When vaginal colonization occurs at or near the time of delivery during pregnancy this organism can become a significant potential pathogen for the neonate.

Since its emergence in the 1970's, neonatal group B streptococcal disease has become the major infectious cause of illness and death among newborns. If prolonged labor or premature rupture of membranes occurs, the neonate may aspirate GBS. This aspiration may result in neonatal sepsis, meningitis or severe respiratory distress characterized as either early onset (infants under seven days of age) or late onset (infants seven days of age or older).

For this reason, the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control (CDC) recommend universal culture screening for vaginal and/or rectal colonization with GBS, as opposed to previous options to either culture or simply assess based on individual risk factors, in all pregnant women between 35 and 37 weeks gestation. There are proper screening methods and techniques that should be followed for optimal recovery of GBS if present. First, proper specimen type and collection site is crucial. The optimal specimen is a vaginal/rectal swab (or swabs) from the lower vagina and rectum area passing through the anal sphincter. Other sub-optimal specimens, such as cervical or vaginal only swabs may be cultured, but these specimens could yield false negative results, and are not recommended. Use of appropriate culture methods by the microbiology laboratory is the next crucial component of proper GBS screening. Many physicians may not know what method their laboratory uses to process GBS cultures. The recommended screening method includes inoculation of both a solid and a selective broth media. A Trypticase Soy Agar with 5% Sheep blood (TSAII) is the usual solid medium used. This primary blood plate is in-

oculated directly from the swab and incubated at 35°C for 18-24 hours in an anaerobic environment. This environment provides a better chance for detecting hemolysis. LIM Broth is a manufactured selective broth media used by many laboratories. This broth is prepared from Todd Hewitt medium supplemented with yeast extract to enhance growth of GBS as well as colistin and nalidixic acid to inhibit growth of Gram negative flora. This broth is inoculated after the primary blood plate by rolling the swab in the broth and expressing residual fluid out of the swab. This media is incubated aerobically at 35°C for 18-24 hours. Following its 24 hour incubation, the blood plate is observed for beta-hemolytic colonies (clearing of agar) demonstrating catalase negative gram positive cocci. Suspected colonies are further tested to determine Lancefield grouping using a methodology such as latex grouping reagent. If GBS is identified on this primary plate, examination of the LIM broth is not necessary. If GBS is not detected the LIM broth is examined for turbidity. If turbid, the broth is subcultured. Following incubation, this plate is examined in the same manner as the primary plate. The basic laboratory guideline to follow is a 48-hour incubation of all plates (primary or subculture) unless determined positive for GBS prior. This rule applies to the LIM broth as well. If turbidity is not observed after 48 hours, the broth can be discarded with no subculture performed. A negative culture is determined by no GBS observed on both plates and LIM broth subcultures. A positive culture is determined by GBS present on either the primary plate or the LIM broth subculture. Susceptibility testing is not routinely performed on positive cultures for GBS. The ACOG guidelines recommend treating pregnant women colonized with GBS with antibiotics prophylatically during labor and delivery. GBS is universally susceptible to penicillin. However, for patients with a serious penicillin allergy, clindamycin and erythromycin are the recommended alternative agents. Because GBS are now developing resistance to these alternatives, susceptibility testing is recommended for these drugs. The physician can inquire with their reference laboratory to determine if susceptibility testing is offered upon special request.

For additional information, updates, or specific research studies, refer to the American College of Obstetricians and Gynecologists (www.ACOG.com)) or the Centers for Disease Control and Prevention (www.cdc.gov).

Colleen Champagne, MT (ASCP) BMC

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Getting Hip In Western Massachusetts

Vinnie Perrone has produced this reflection after spending some time on the other side of the stethoscope and in addition on the other side of the scalpel."

"Good Morning!" "Good Morning!" right around middle C,
The admitting charge nurse was welcoming me
To a table and chair near an unfolded screen
Where one could disrobe without being seen.

"Your wallet and watch in the plastic that's clear."
"Your cloths and whatever, the other sack here."
"Don't make yourself ill with worry and fretting."
"This is 'old hat', and were not above letting"
"You know that hopes and our aim and your hope is the same."
"Undoing the bother that's making you lame."

Next, Anesthesia, and as he took my measure,
"Just look at those veins," with undisguised pleasure
He said, and he added, palpating my skin,
"With a push here and there we'll gently slip in"
"Number eighteens or twentys, whatever's required"
"For fluids and drugs, even blood, while you're wired"
"To meters of oxygen, pressure and pulse"
"And other parameters helpful to us"
"In seeing you through this bloody endeavor"
"That will quit you of pain at once and forever."

Then into the O.R.,"Hello", my name is Laura."
Magic cool fingers weaving an aura of winds
Wafted me swirling through sensuous rains
As the drugs she was pushing ascended my veins,
But even as high as I flew and I hovered,
"Gracious!", I worried, "Am I somewhere uncovered!"

"Curl yourself into a ball, if you can!"
A male voice commanded as gloved fingers ran
Over lower thoracic spine tips to those lower down
To a mid lumbar level he chose for that, "Pinch and a burn,"
Which so aptly described the 'local' preceding the spinal prescribed.

It was ten after eight when the draping was done.
Little was said as the case was begun,
Time passed, and I drifted this time on a sea
Of rolling indifference to the world around me.
The clang of a hammer the whir of a drill,
That all seemed in focus, though far away, still.
Desultory chatter of politics, then...
The clock being watch said ten minutes to ten.
A call for more two-0, "Could it really be true?"
"They're closing the wound; the Surgery's through!"

Recovery, x-ray, a touch of sedation
Then out in the hall to some nurse's station,
To a room with a bed with an overhead bar;
It was all just so easy, like 'clock work' so far.
But, "Oh!" the tomorrows! The four days to come!
Tied down to a the bed with a Foley and some-
One or other deciding what's best,
When to be active how much to rest....
Enough to unnerve the calmest of men
Among whom, "I admit it." I never have been.

But each day did pass, the wound slowly healing
The fourth day arrived and in spite of feeling
Put upon, hurt, and wretchedly lonely
Escape into sleep required that one only
Turn one's head, thusly, and with eyes slovenly closed
Slip off into slumber. But you know as I dozed
Warm fingers encircled my hand and my cheek
Was brushed by soft lips that made my heart weak.
A soft voice then came before wild thoughts could roam,
"It's me, Dad, I've come, and I'm taking you home."

Vincent Perrone, M.D.

A MALPRACTICE DEFENSE LAWYER'S VIEW OF TORT REFORM

10th Annual Medico-Legal Forum

On March 25, 2003, the Hampden District Medical Society and the Hampden Country Bar Association's Medico-Legal Committee sponsored a forum on "Tort Reform" at the Log Cabin in Easthampton.

Over one hundred lawyers, physicians and other interested individuals were in attendance. We were very pleased to have the benefit of an outstanding panel of experts: Barry Manuel, M.D., Chairperson of the Board of Directors of ProMutual; Charles Welch, M.D., President of the Massachusetts Medical Society; and Valerie Yarashus, Esquire, President of the Massachusetts Academy of Trial Attorneys. Each speaker did an outstanding job of presenting "their side of the story". Needless to say, Ms. Yarashus expressed the "minority view" for the group in attendance. However, even those who have a polar opposite view of the justice system benefited by hearing Ms. Yarashus' remarks. Now, the physicians in attendance should be better educated as to the points that will be made by the "other side".

For most of the last two decades I have been defending medical professionals in the Massachusetts' courts. As such, medical malpractice reform has always been a subject of interest. In Massachusetts, we have had what some may describe as medical liability reform with the tribunal system, a soft cap on non-economic damages, and a sliding scale on contingent fees. However, in my view, these reforms, although on paper having some appeal, in practice, have had little or no impact.

Although medical liability reform has, for many years, been a subject of great interest to lawyers and physicians it has not been, in my view, an issue which has captured the public's attention until quite recently. Last month, the House of Representatives voted in favor of legislation which was championed by President Bush which, among other things, proposed to place a $250,000.00 cap on non-economic damages.

I believe this issue has captured the attention of the public for one reason: for the first time it is not perceived to be simply a turf battle between lawyers and doctors. Instead, the issue of liability reform appears to have relevance to the healthcare consumer. On the one hand, we have the local example of obstetricians leaving the area or the practice entirely leaving behind a shortage of physicians available to deliver babies. On the other hand, we have the tragic nationally publicized case out of Duke University Medical Center involving the botched transplant of organs to a teenage girl which will serve as a poster case for those who advocate against across the board caps on damages.

It is my personal belief that there is no silver bullet solution to these problems. Nor do I believe that tort reform alone will provide physicians with much needed financial relief.

I encourage physicians and others in the healthcare field to fight for tort reform. However, in my view, the recipe for success in this regard must include the following: 1) overwhelming participation by the medical community; 2) significant participation by patients who have been affected by the loss of services; 3) inclusion in the debate of other subjects which, in the view of many, have had a more drastic impact on the financial conditions of physicians including the woefully inadequate reimbursements that Massachusetts' physicians are presently receiving.

There has never been a better opportunity for physicians to achieve meaningful, healthcare reform. Don't let the opportunity pass you by.

John G. Bagley, Esquire
Morrison, Mahoney, and Miller, LLP

Tort Reform

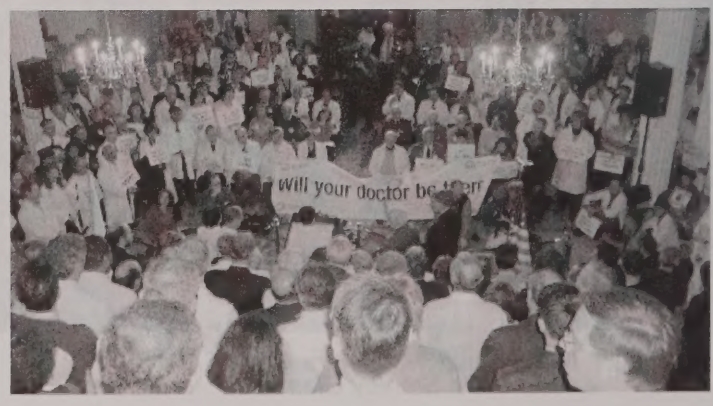
Left to right: Attorney Valerie Yarashis, President of the MA Academy of Trial Attorneys, Dr. Barry Manuel, Chairperson of the Board of Directors of ProMutual and Dr. Charles Welch, President, MMS.

Left to right: Attorney Valerie Yarashis, Attorney John Bagley, co-chair Medico-Legal Committee, Dr. Mark Mullan, co-chair Medico-Legal Committee, Dr. Charles Welch, President, MMS and Dr. Dennis Gordan, President, HDMS.

Left to right: Dr. Suen-Tien Lin, Dr. Joel Bessof and Dr. Stanley Glasser.

Dr. Robert Goodwin and Attorney Ted Brown

The Rally at the State House



April 8, 2003

In an unprecedented demonstration of political activism by Massachusetts's physicians, a crowd that may have exceeded 1000 doctors, staff members, and patients attended the rally over tort reform at the State House. In his address to the crowd at the foot of the grand staircase, a sea of white coats all around, Governor Romney threw his support to the tort reform bill. His remarks were followed by a summary of the problem by Dr. Charles Welch. Dr. James Wang then described the difficulty of his decision to stop providing obstetrical care because of impossibly high malpractice insurance rates. Two of his patients came after to describe the impact on their lives of the loss of their doctor.

After a break for lunch, the western Massachusetts contingent, which was disproportionally large in comparison with attendance from other regions, moved into a legislative testimony room. Speaker Thomas Finneran addressed over 100 physicians and expressed his support for measures to bring tort suits under better control He was sympathetic to the problem of loss of senior physicians and difficulty recruiting new ones. He was accompanied by a sampling of the legislative panel serving the Connecticut River Valley: Senators Lees and Rosenberg, Reps Story, Petrolati, Buoniconti, and others gave their views on the problem of tort reform. Probably the most striking views came from Rep. Buoniconti, who reminded the audience that their opponents, trial attorneys, have made cogent arguments that no tort reform bill will achieve the goal of reduced insurance costs. They remained to hear testimony from physicians, who pressed the points that the access to care is compromised by the present situation.

After that conference, some physicians went to visit the offices of their local representatives. I briefly visited Rep. Mary Rogeness, who gave her support to tort reform and who also asked for support of stricter laws relating to drunk driving. Clearly, the medical societies support these concepts, and I told her that we appreciated her support for our issue.

The legislators also described the relationship between government and the governed. They reminded physicians that a one-time rally to the State House will not achieve its goals, and there must be ongoing dialogue between constituents and legislators. We were encouraged to come to testify on measures, such as the tort reform bill, when they are brought to committee hearings. We were reminded that we should keep in contact with our legislators, ideally in person, but at least by letter. If we are not part of the process, we cannot have any stake in the outcome. Rep. Finneran described the legislators as having little knowledge about our work and concerns, but having great interest in learning about the issues pertaining to medicine in the Commonwealth. He stated that we have a duty to educate the government, which means that we must participate in the legislative process.

Jeffrey L. Kaufman MD

Students Become Dr. for a Day

By Andrea Bugbee

Anyone who thinks that a day in the life of a high school student isn't exactly brain surgery hasn't met John Saulenas. Watching brain surgery was part of the day's routine for Saulenas, who was one of twenty-six local students selected to participate in the Hampden District Medical Society "High School Doctor for a Day" program.

"I thought it was very interesting and very helpful," said Saulenas, a junior at Southwick-Tolland Regional High School who has wanted to become a physician since he was little. With only one in four applicants accepted into the High School Doctor for a Day program, Saulenas and his peers shared a rare glimpse of what they hope will one day be their own futures.

"Not every student in high school has the opportunity to figure out exactly what they want for the next 20 years, so I feel blessed," remarked Nathaniel Ryan, also from Southwick.

Ryan, who shadowed Internist Dr. Shaukat Matin, was surprised at the deep level of doctor/patient interaction he observed. "It's more personal than I thought. [Dr. Matin] isn't just prescribing medicine, he's getting to know his patients, their families, their lives, and how it effects their health."

Being a physician, Ryan also noted, is constant work. "It's a way of life," he said. "When you're not in the office, you're on call." But seeing such demands firsthand left this enthusiastic future physician undaunted. "In my mind, there is nothing I would rather do," he said. "It's something that's really meaningful. It effects other people's lives – and I feel it is my calling."

Karen Quill, a Westfield High School senior recently accepted to the University of Vermont School of Biology and Health Science said that, before becoming a "doctor for a day," the only medical experience she'd had was as a patient. Working with Oncologist Dr. Alicia Ross, Quill was grateful to observe a wide variety of tests, exams, and procedures. "Well," she amended, "I passed out during surgery. Other than that it was fine."

Conversely, Southwick's Brittany Canfield observed two hand surgeries without feeling at all queasy. "It was something new and exciting," stated this robust, three-sport scholar/athlete. One of the surgeons participating in the program did note, however, that from his perspective, the less "exciting" a surgical case, the better.

Ashley Bessette of Westfield followed Internist and Pulmonologist Dr. Stanley Glasser for the day. "It was a really positive day," she said, commenting that she was struck by the wide variety of patient personalities and illnesses. Like Canfield, Bessette was also exhilarated by her day's experiences. Compared to a day at school, she said, being a doctor for a day was, "...more busy, active, and interesting. More challenging."

However, not all of what students observed was exactly thrilling. Ross, the program's coordinator, remarked that many young people expect medicine to be glamorous and dramatic as it is portrayed on television. "It's all a contrived situation," she said. "But there's also the boring part of medicine." So,

High School Doctor for a Day

clad in their white lab coats, students also observed phone calls, trips between hospital and office (and back again), and mountains of paperwork.

One student remarked that he now knows how it feels to remain on his feet for seven hours straight.

Designed as a mentoring opportunity to benefit serious high school students intent on becoming physicians, the Doctor for a Day program gives students an opportunity to see medicine as it truly is, said Ross. "It gives them a real-life look at what we actually do."

And, Ross added, the physicians who mentor these students also benefit. They get the boost of seeing their somewhat mundane routines through younger eyes. "It's such a refreshing change," she said. "It reminds us of when we were first interested in medicine."

"Some people spend the majority of their young adult lives trying to decide what type of occupation to pursue," said Westfield High School Junior Lora Bash. "For the last eight years I have dreamt of no other career than of being a physician."

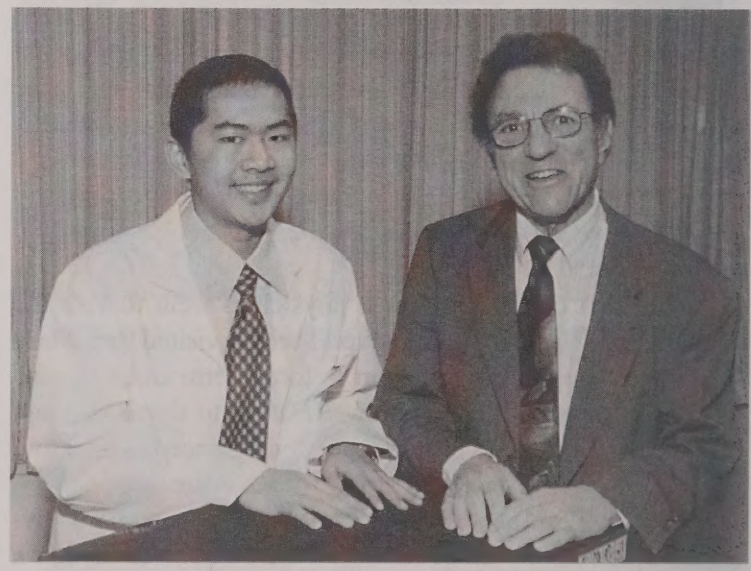
Thanks to 22 welcoming Hampden District Medical Society physicians, Bash's dream has come true.

At least for a day.

Reprinted with permission from the Westfield Evening News

Dr. Cecilia Conception and student Lora Bash

"The High School Doctor for a Day program was, for me and hopefully for the student- a great success. The "secret" of the success of the program is a clear demonstration to the upcoming generation of our love for our profession and our drive to pass that on, going forward." *— Dr. Mark Sherman*



Toan Dinh and Dr. Mark Sherman

Nurse Anesthethist Paul Mercaitis and student Brit Canfield

Doctor for a Day Thank You

Nathaniel and Dr.Shauhot Mateen

The ability to learn how to heal another person is one of the greatest opportunities available in life. I, Nathaniel Ryan, am set and determined on my future plans in the medical field and in my mind there is nothing that I would rather do. I wish to participate in the High School Doctor for a Day program in order to gain hands-on experience and take advantage of the learning opportunity being offered.

Throughout my time in high school I have been fascinated with science and have been excited mostly by courses I have taken in biology and chemistry. My dream of becoming a medical doctor materialized in the beginning of my sophomore year when I was immersed in advanced math courses and began my biology class. I loved working the in the lab and from that class went right on to chemistry and then physics. My passion for these areas of study has only increased since then and I know that medicine is the only profession for me. I have earned a 94.47% GPA and put enormous amounts of work in my studies. The High School Doctor for a Day program would place me in the atmosphere that I wish to spend a great deal of my life and help me choose what branch of medicine I should pursue. Since I am still only in high school and have no real experience on the work site, I cannot yet be positive on what specialty I would make my goal. So, this experience would act as a tool by placing me right beside a certain professional. I have worked hard these past years and am prepared for studies that are more difficult than anything I can experience in high school.

Not every student in high school has the opportunity to figure out exactly what they want for the next twenty years, so I feel blessed. I also feel that I should explain my specific plans for the future before being considered for the High School Doctor for a Day program. I would really like to start my college years at either the University of Massachusetts or Boston University. These two schools appeal to me for a few reasons: they both have excellent science departments, medical schools, and the Reserve Officer Training Core. I believe that I would like to earn a major in Biochemistry and from there go on to medical school. However, I also feel that one of the greatest opportunities available to citizen is the chance to serve the United States in the armed services. That is why I will be joining the ROTC programs at my future college and serves my time after I graduate. These are the plans I have laid out for my life, and I am eager to get started as soon as possible. I am willing to take any chance at learning more about the various fields of medicine in order to better prepare myself for the goals I hope to achieve. The High School Doctor for a Day program is one of these chances, and I would like to participate to gain advice and guidance straight from the professionals.

Thank you for considering me,
Nathaniel Ryan

HAMPDEN DISTRICT MEDICAL SOCIETY

Annual Meeting

Tuesday, May 6, 2003

Iraq, Nuclear Weapons and Pre-Emptive War

Presented By: Ira Helfand, M.D.

Co-Author, "Accidental Nuclear — A Post-War Assessment"

1 Hour in Category 1 Credit Risk Management Study, for Physicians

Elections, State of the Society Address

Fifty Year Membership Awards

Announcement of the

"2003 Senior Volunteer Physician of the Year"

"2003 Community Clinician of the Year"

Place: Carriage House at the Barney Estate (Forest Park)
200 Trafton Road, Springfield, MA
Time: 6:30 p.m.

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